DOCUMENT RESUME

ED 454 642 EC 308 446

AUTHOR	Guthmann, Debra
TITLE	Counseling Deaf and Hard of Hearing Persons with Substance Abuse and/or Mental Health Issues: Is Cross Cultural Counseling Possible?
INSTITUTION	Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals, Minneapolis.
PUB DATE	1999-00-00
NOTE	30p.
AVAILABLE FROM	For full text: http://www.mncddeaf.org.
PUB TYPE	Information Analyses (070) -- Reports - Evaluative (142)
EDRS PRICE	MF01/PC02 Plus Postage.
DESCRIPTORS	Adolescents; Adults; Alcoholism; American Indians; *Counseling Services; *Counseling Techniques; Counselor Client Relationship; *Cultural Awareness; Cultural Differences; *Deafness; Hearing Impairments; Illegal Drug Use; Mental Health Programs; *Minority Groups; *Substance Abuse
IDENTIFIERS	*Deaf Culture; Minnesota

ABSTRACT

This paper discusses the complex issues faced by clinicians providing counseling to chemically dependent individuals who are deaf or hard of hearing and who are from ethnic, racial, or cultural minority groups. It shares specific examples from the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals, as well as suggestions for delivering effective clinical services. Recommendations include: (1) openly address issues of ethnic and/or cultural differences and lack of knowledge about the client's background; (2) evaluate the degree of the client's status related to culture, acculturation, or multicultural fluency by using individual cues; (3) allow time for trust to develop before focusing on deeper feelings; (4) be aware that some cultures avoid eye contact and that even if the client does not maintain eye contact, this does not mean disrespect or lack of attention; (5) know the current climate and issues of concern in the deaf community, and (6) be aware of cultural factors that actually are barriers to treatment and recovery and those that are not. An appendix contains a list of American Indian, Anglo, and deaf community characteristics. (Contains 24 references.) (CR)

Reproductions supplied by EDRS are the best that can be made
from the original document.

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL HAS BEEN GRANTED BY

Guthmann

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

1

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☐ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

ED 454 642

Counseling Deaf and Hard of Hearing Persons with Substance Abuse and/or Mental Health Issues: *Is Cross Cultural Counseling Possible?* by Debra Guthmann, M.A., Ed. Specialist, Program Director, The Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals

Chemical dependency treatment services for alcohol/drug related problems can be found in most communities, but these services are rarely culturally appropriate or accessible for Deaf and hard of hearing individuals. These individuals encounter many barriers when attempting to secure treatment services. Additional barriers are faced when trying to adequately serve Deaf and hard of hearing individuals who represent a racial or ethnic minority group. Cross cultural competency is necessary if treatment is to be effective and accessible to Deaf clients within a chemical dependency treatment program. The purpose of this article is to discuss the complex issues for clinicians providing cross culturally sensitive counseling to chemically dependent deaf and hard of hearing individuals who represent an additional variety of ethnic, racial or cultural minority groups. Specific examples will be shared as well as suggestions for delivering effective clinical services to this population.

What is Culture?

Culture has been defined as: "The shared values, norms,

EC 308446

BEST COPY AVAILABLE

traditions, customs, arts, history, folklore, and institutions of a group of people"(Padden,1980). Leong and Kim(1991) refer to Brislin's (1990) definition of culture. "Culture refers to the widely shared ideals, values, formation and uses of categories, assumptions about life, and goal-directed activities that become unconsciously or subconsciously accepted as 'right' and 'correct' by people who identify themselves as members of a society" (Leong & Kim, 1991, p.112). Schein (1989) reminds us that culture encompasses institutions, folkways, mores, art, and language. The intent of this article is not to provide further evidence that a Deaf culture exists, but to demonstrate the importance of recognizing therapeutic issues related to cross cultural counseling within the deaf population. (Padden, 1980; Padden & Humphries, 1988; Rutherford, 1988).

What is cross cultural counseling and How Can it be Successful?

Cross cultural counseling is the process of counseling individuals who are of different culture/cultures than that of the therapist(Burn, 1992). Much of the information provided on this topic in professional journals and training programs focuses on ethnic or racial groups and the impact culture has on the development of substance abuse problems and subsequent therapy. The Deaf population as well as other ethnic and cultural minorities are extremely varied and it is impossible to make general recommendations regarding counseling that would accurately apply to all these diverse groups. It is therefore

important not to stereotype any one group based on general assumptions. It is important for counselors to be sensitive to and considerate of a client's cultural makeup. Clinicians encounter many challenging and complex issues when attempting to provide accessible, effective, respectful and culturally affirming chemical dependency treatment to a multi-cultural population of Deaf and hard of hearing individuals.

Recently, counseling of deaf individuals has gained recognition in the discussion of cross cultural counseling. Often, tri-cultural counseling situations are encountered with this population since a deaf client may also represent various ethnic and racial minority groups in addition to being a member of the Deaf community. Approximately 75% of Deaf Americans use American Sign language(ASL) as their primary means of communication(Vernon, 1991). Therefore, ASL becomes the primary criterion for identification of membership in the Deaf community and for promotion of solidarity within the group. Historically, hearing professionals have had little knowledge about the Deaf community and were unable to communicate in ASL. The Deaf community has been subjected to rejection and domination by the majority(hearing) culture and because of this, education related to alcohol and other drug abuse has not matched that of the general population(Rendon, 1992).

Ethnicity and culture is part of each person's development. Culture is not only a minority experience but also the experience of members of the majority culture. Therefore, it is important

for counselors to develop an understanding of culture in two respects. The first, and most obvious, is to become aware of the client's culture, and secondly for the counselor to develop an understanding of his or her own culture including its overt and covert influences. The recognition of cultural differences becomes critical within the context of the counseling setting. For example, hearing persons tend to place personhood ahead of cultural issues while Deaf people may think of themselves as Deaf first and a member of a specific ethnicity second. The Rationale which some researchers suggest is that a common language allows for an ease of communication which creates a bond and a basis for the transmission of the culture. Other researchers, however, have emphasized that for deaf members of ethnic minority groups, the predominant cultural identity may be the home culture because of the strength of the traditions in the community and the immediate recognition of the ethnicity, while the deafness may at first be invisible.(Eldredge, N. & Hammond S., 1992).

MCDPDHHI Program Description

The Minnesota Chemical Dependency program for Deaf and Hard of Hearing individuals(MCDPDHHI) is a program specifically designed and staffed to meet the needs of Deaf and hard of hearing individuals. Cross cultural counseling is an integral part of a client's treatment. The program is part of Fairview Riverside Medical Center in Minneapolis, Minnesota and serves

individuals sixteen years of age and older from the United States and Canada. Since it's inception in 1989, the program has worked with over 375 clients from 46 states and 4 provinces in Canada. The MCDPDHHI is unique in that staff are fluent in American Sign Language(ASL), respectful of Deaf culture and have expertise working with chemically dependent individuals who are Deaf or hard of hearing.

A multidisciplinary approach is used with the 12-step model as its therapeutic foundation. A variety of services are offered to individuals in the course of their treatment including: chemical dependency assessment, communication assessment, nursing and medical care, chemical dependency education, coping and decision-making skills training provided by a certified teacher of the Deaf, psychological testing, spiritual care, individual and group therapy, occupational therapy, recreational therapy, access to outside AA/NA meetings, individualized treatment planning, family therapy, and aftercare planning.

Therapeutic approaches used in the treatment of clients are psycho-educational in nature. Flexible and creative approaches based on the 12 steps of AA/NA are used to offer clients information they can use to effectively change their lives. One important reason for choosing a 12 step approach was the availability of 12 step meetings and groups all around the country. A visual approach is emphasized and all education, information, therapeutic interaction and other activities are adapted to the individual's specific communication needs. Clients

have a wide variety of clinical needs, ethnic and cultural backgrounds, communication needs/styles, mental health diagnoses, and other idiosyncratic issues. Staff attempt to create and implement treatment plans designed to meet the needs of each individual client entering the program.

The cross cultural therapeutic relationship

When a hearing counselor enters into a therapeutic relationship with a Deaf client, cross cultural counseling may very well be considered multi-cultural counseling. A Deaf clinician who enters a counseling relationship with a Hispanic Deaf person is also engaging in cross cultural counseling. A counselor's sensitivity to a client's cultural makeup is critical in the development and process of the counseling relationship. At the MCDPDHHI, it is not unusual to have Deaf clients from extremely diverse backgrounds programming together within the same milieu. A white female from a rural community who has hearing parents and attended a mainstream school without the assistance of an interpreter may be in treatment at the same time as an African American, inner city, gay male who grew up in a home with Deaf parents and went to a residential school for the Deaf. Realistically, it is not possible to match a given client with a counselor who represents each of the same cultural and ethnic characteristics of the client, but it is critical for clinicians providing substance abuse counseling to this population to be sensitive to the cultural and therapeutic needs of clients.

Nancy Eldredge has done a great deal of research in the area of culturally affirming counseling with American Indians who are deaf. She discusses the difference between the orientation to time and space within the Deaf, Anglo and Indian cultures.(Appendix I.) Within Indian cultures the emphasis is on the present. The legends from the past are valuable as metaphors for the present, as well. Time is viewed spatially rather than in a linear sequence of seconds, minutes and hours; and events scheduled to occur at a specific time may not be important to many Indian individuals(Everett, Proctor & Cartmell, 1983). Within Deaf culture, the orientation is to the past or present. Stories that are told are carriers of history, ways of repeating and reformulating the past for the present(Padden & Humphries, 1988). There is an awareness of time and schedules within the deaf community but there is a difference in the degree of importance of the schedule in comparison to Anglos. Each deaf American-Indian deals at home with a strong tribal culture and at school with Anglo society and often deaf culture as well. After these individuals finish school they may need to make a decision about returning to the reservation which may mean limited communication but access to their culture or living in urban areas within the deaf community with limited cultural access. This is an important perspective which the effective clinician must appreciate. Often people in the field of deafness or the deaf community refer to "Deaf Time": meaning that Deaf people don't start events "on time," which may be because deaf people

put more emphasis on people and relationships than the time clock(Padden, 1980). If a meeting is scheduled to start at 8:00, people may arrive and greet each other at that time, but often the formal meeting doesn't start until 8:30.

The issue of time and space orientation is important when setting up a counseling schedule which may only allow for a 50 minute session or on an inpatient treatment unit where a daily schedule is posted and clients are expected to be on time for activities. The counselor may need to set up a contract with the client so they are aware of the time the session will begin and end. Counselors should be sensitive to the cultural differences this kind of schedule expectation may mean to some clients. This may mean clarifying and explaining why time expectations are important. At the MCDPDHHI, this may mean that the first or second time a client is late, the counselor will sit down and explain the expectations. By the third time, the counselor would hope that with the help of the client's peers, they would see the importance of being on time for scheduled activities. The counselor would also emphasize the concept of respect and wanting to be on time so they can benefit from the group therapy experience.

In order to be a competent counselor within a cross cultural setting a clinician must have personal mental health, self awareness, the ability to communicate with cultural sensitivity and adequate supervision(Schein, 1989). It is the responsibility of professionals in the mental health field to attend to their

own mental health and continuously challenge any existing biases that may exist that can create barriers to being an effective clinician. In a recent article Sabatini, Ponterotto, and Borodovsky (1991) discuss the importance of focusing on not only the client's cultural identity development but as importantly on that of the counselor. They believe that developing multi-cultural sensitivity and competence, particularly for those culturally encapsulated counselors unaware of their own ethnocentric biases is a long term developmental task. In Lockes'(1991) Paradigm of Cross Cultural Counseling he proposes that self awareness is the first step in getting to know others. He recommends that individuals consider the following questions as one way of clarifying their self awareness:

1. What is my cultural heritage? What was the culture of my parents and my grandparents? With what cultural group(s) do I identify?
2. What is the cultural relevance of my name?
3. What values, beliefs, opinions and attitudes do I hold which are consistent with the dominant culture? Which are inconsistent? How did I learn these?
4. How did I decide to become a counselor? What cultural standards were involved in the process? What do I understand to be the relationship between culture and counseling?
5. What are my unique abilities, aspirations, expectations and limitations which might influence my counseling with

a culturally different client?

It is important for clinicians to think about each of these issues and have an understanding of where they stand prior to entering into the counseling relationship with a client. Susan Cayleff (1986) illustrates the importance of the need for counselor competence in stating that:

> The counselor-client relationship operates as a microcosm of the larger American social structure and reflects the beliefs, stratifications, tensions, and injustices that exist in American society. ... Like the physician-patient relationship in the medical model,the counselor-client relationship is hierarchical and thus replicates the power dynamics evidenced in other nonpeer relationships. Because professional counseling personnel have only nonspecific ethical guidelines by which to conduct their interactions with culturally non dominant populations...counselors should be aware that their own place within the larger culture-their social status, sex and race - will probably influence both what they perceive as problems and the dilemmas and how they respond to them(p. 345).

Fitzgerald and O'Leary (1990) identify essential personal characteristics for the effective cross cultural counselor. They refer to Ivey's (1977) depiction of such an individual as one who has "communication competence, ability to generate new ways of

describing the world and adaptability to ever-changing situations. The 'multi-cultural person', is someone who is adaptive, continually in transition, and grounded in his/her own cultural reality(Fitzgerald & O'Leary, 1990, p. 239). Sue and Sue (1990) reinforce this in describing the culturally skilled counselor as one who works toward the goal of becoming more competent. They identify three tasks which are involved:

1. Actively in the process of becoming aware of his/her own assumptions about human behavior, values, biases and so on;
2. Actively attempts to understand the view from the clients perspective;
3. Actively involved in developing and practicing appropriate and sensitive strategies for working with clients.(p. 166).

Finally, Leong and Kim (1991) list three areas of competencies recommended for the culturally skilled counseling psychologist:

1. Beliefs and attitudes-be culturally aware, in touch with own biases about minority clients, comfortable with the differences and sensitive to situations which dictate referral to a same culture counselor.
2. Knowledge-including understanding of sociopolitical factors effects on minorities, specific knowledge about the group being served and understanding of institutional barriers for the minority client seeking services.
3. Skills-ability to respond in a variety of ways verbally and non verbally, ability to send messages accurately and ability to use appropriate institutional interventions.

Strategies for Clinicians working with Deaf and hard of hearing clients

For counselors seeking competence in working with persons who are deaf, clinicians need to be aware of cultural issues related to: identity, maintenance of cultural group boundaries through bilingualism(English and ASL), enculturation into the Deaf Community, an organized social network and shared experience of stigma, and potential inferiority stereotyping by the majority culture. Cultural identity is established primarily through the use of ASL and promotes unity in the group. Interaction between deaf and hearing people as compared to interactions within the Deaf Community are marked by bilingualism.

The ideal counseling situation consists of one where the counselor is able to communicate with the client in his or her preferred communication style. In order for effective counseling to occur, both the counselor and client must be able to send and receive both verbal [signed] and nonverbal messages accurately and appropriately(Sue & Sue, 1990). Effective communication, interpersonal sensitivity and communication skills are imperative in any counseling relationship in order to establish trust and rapport in the counseling relationship. These considerations are especially critical when encountering cross cultural counseling situations. In order to create a culturally affirmative treatment milieu, the most important task is to affirm and use the language of the Deaf Community, ASL(Glickman & Zitter, 1989). Clinicians working with Deaf clients need to be ale to communicate with each

individual client in ASL, Pidgin Signed English, Signed English, Cued Speech, gesturing, drawing, spoken English or written English. A client should not have to change his/her mode of communication to meet the clinician's proficiency level while also dealing with a variety of other clinical issues. Competence in the language of the culture is the chief component to cultural sensitivity(Glickman, 1983). Westwood and Ishiyama(1990) feel that it is important when working with ethnic clients for the counselor to understand the client's subjective experiences, goals, ways of behaving, life plans, and other significant areas. Often times, clients from various ethnic and/or cultural minorities are preoccupied in the initial stages of counseling while trying to determine if the clinician will be able to understand them. "We have repeatedly observed in our clinical experience that ethnically distinct clients often show therapeutic improvements when a counselor effectively acknowledges and validates their inner world of experiences, which were previously neglected or uncommunicated to others" (Westwood and Ishiyama, 1990 p. 165).

Counselors who fit these descriptions and who have taken responsibility for their mental health and any biases they may possess can be effective in a multi or cross cultural counseling setting.

The process of becoming an effective counselor who is able to work in a variety of multi cultural settings is an active process that is ongoing. Clinicians must also recognize the

diversity of the client population being served and know when to acknowledge personal limitations and/or the need to improve specific skills.

Chemical Dependency Treatment Philosophy

Chemical Dependency treatment for the most part, has grown out of the Alcoholics Anonymous movement. The overall emphasis has tended to be to ignore the individual differences and similarities of each client in order to achieve a positive therapeutic outcome. The importance of reaching out to others and not isolating yourself is stressed through the use of sponsors and self-help groups such as A.A., N.A. and C.A. The civil rights movement stressed equality for African Americans and other minority groups but has been called culture or color blind by some people because it focused on the importance of treating everyone the same. Later in the sixties and with the Gallaudet revolt the theme has been one of recognizing individual uniqueness as well as striving for individual rights.

Paul Pedersen,(1976) formerly of the University of Minnesota, has written of what he calls "The Culturally Encapsulated Counselor." Pedersen states: "As the counselor works with persons belonging to a life style different from his own for any length of time, he participates in and contributes to a process of acculturation by himself and his clients."

Historically, treatment of deaf individuals has been culturally insensitive and this situation must change in order to

provide effective counseling services to this population. Clinicians should make sure that they do not assume that all Deaf people have the same communication preferences or that all come from the same background. In a treatment setting, the culturally sensitive counselor will recognize and respond to individuals with a range of communication modes and backgrounds. The following examples illustrate this point. In an inpatient program for deaf persons the group may include the following individuals who are all in treatment simultaneously: a Native American or Canadian, raised in a rural area with no deaf peers and who communicates using home signs(a gestural system developed in the home environment for communication); an inner city, white, Hispanic or African American client who attended a residential school for the deaf, who uses ASL as the primary means of communication and who is quite streetwise; and a client who was educated ir a mainstream setting, uses Pidgin Signed English and grew up in a small town. Such a wide variety of communication modes and personal experiences poses a challenge for treatment staff who are attempting to meet the cultural and communication needs of deaf individuals.

The Deaf population, as well as other ethnic and cultural minorities, are extremely varied and it is impossible to make generalizations related to approaches that work with all chemically dependent individuals from diverse ethnic backgrounds. This intra group diversity poses particular problems for the counselor. He/she may work with one minority client who presents

A particular set of behavior, attitudes and feelings and the next client may be completely different. This should not be a surprise to a counselor since most of us do not know any other two individuals who have the same personality traits. Counselors should also keep in mind that women,gay and lesbian individuals, Deaf individuals and other ethnic and racial minorities have been oppressed in this society. This oppression may present itself in counseling sessions with psychological manifestations.

When counseling services are provided in the context of treatment for substance abuse problems, Deaf culture likewise may have an impact. Similar to many other minority cultures, experiences of oppression and discrimination result in a "protective posture" by the community. "The culture of the deaf often provides a shelter and a barrier to recovery by encouraging isolation and denial"(Rendon, 1992). Patterns of socialization which are a part of the culture also impact on the provision of substance abuse services. Valuing and respecting differences between deaf and hearing people and having a good understanding of one's own values and biases are crucial to providing effective counseling services for deaf individuals. Cross cultural counselors need to be comfortable with the difference that exist between themselves and their clients without denying or trying to change these differences. For example, to many deaf adults, the Deaf club is the center of Deaf community activities and the primary opportunity for socialization. However, the sale of alcohol often is the main source of financial support. The

counselor in such a situation must be sensitive to the struggle this presents for the recovering deaf person. In treatment, a client may learn of the need to develop new relationships with sober people upon their return home. However, many communities have small numbers of deaf people many of whom may be substance users or abusers.

Counselors working with deaf clients should consider working together with other professionals(either within or outside of their own agencies) to help meet the cultural needs of the client. For example, if the counselor has skills to deal with the deafness aspect but is not able to meet the other cultural needs of an Hispanic client, he/she might utilize a Hispanic professional and an interpreter to address the client's Spanish cultural issues. Similarly, counselors can utilize cooperative planning to make ethnic cultural events available to their deaf clients. An example of this might be providing an interpreter for a Native American client to attend religious ceremonies(e.g. sweat lodge, smudging, burning of sweet grass) while in treatment.

As previously mentioned, many deaf individuals may be bi or tri cultural. An example of this would be a deaf chemically dependent Native American Individual. It is important to consider the cultural issues related to an individual's deafness as well as his/her cultural heritage. At the MCDPDHII, clinicians attempt to be sensitive and respectful in relation to Deaf culture and allow the clients from ethnic minority groups

the opportunity to participate in cultural activities offered with deaf and hearing clients throughout Fairview Riverside Medical Center's adult and adolescent chemical dependency programs.

Prior to entering the MCDPDHHI, clients often have not been fully exposed to their cultural heritage and its' various ceremonies or celebrations. An example of this would be with a client who was Deaf, mentally ill and Native American. Her father was very prominent within the tribe she was from and they were fairly traditional. She had been exposed to a number of different ceremonies such as sweatlodges, burning sweetgrass and ceremonial dancing. She had not had the communication provided to her which would enable her to fully understand the ceremonial meaning. While at the MCDPDHHI, she was exposed to a variety of cultural opportunities and was able to interact with other native women through an interpreter. This opened up a new sense of pride and understanding. Without the communication, this would not have been possible for her.

Once Deaf and hard of hearing individuals from various ethnic backgrounds complete treatment, they will need to decide where to live. An example of this may be with a recovering African-American individual who may feel more comfortable returning to the old neighborhood, but there they are more likely to run into drug-using friends. Recovering individuals need to select a community to live in which will enhance the chances for sobriety. Peter Bell(1992) has developed a list of questions a

person should ask when they are making the decision about returning to the previous living environment.

If I decide to stay in my home community:

*Have I listed all the places where I bought or used drugs? How will I now avoid them?

*Have I been honest with myself about the need to avoid them? If I used at the barber's, am I being straight with myself that I need to find a new barber? Have I thought about where I will go for my next haircut?

*Do I have a plan for how I will face friends in my apartment building whom I used with? What will I do when I see them again? Will I tell them I am recovering? Will I try to avoid them? Will I make up a story?

*How will I handle facing people I have harmed or cheated when I was drinking alcohol or using other drugs?

* How will I respond to the put-downs of dealers when I no longer buy?

*How will I respond to people who don't believe I really have changed?

If I decide to move to a different community:

*Have I considered the loneliness and strangeness I might feel living in a new area where I know few people?

*Do I have a plan for how to make new friends?

Have I thought about transportation to my job, arrangements for child care, proximity to shopping areas? How can I begin dealing with these issues and avoid being overwhelmed?

Who can help me?

*If I have left the black community, do I feel guilty and, if so, how will I deal with this guilt?

Variables to consider when selecting appropriate Counseling Services

Many variables need to be considered in determining the most appropriate kind of counseling services. First, the desires of the client need to be known. Whether to use a hearing or deaf counselor is an important as well as difficult issue, since each may have strengths and skills to offer the client. The choice of recovering vs. non-recovering counselors is also significant. One should be aware of the difficulty in finding deaf counselors trained to work with mental health and c.d. issues. This task becomes even more challenging when attempting to find deaf minority individuals to work in these areas. There is a tremendous need to prepare and train individuals to work in cross cultural or multi-cultural counseling situations.

The reality of the current situation is that in most parts of the country, many clients will work with therapists or counselors who are culturally different. While efforts are made to train qualified deaf counselors, hearing counselors can continue working toward developing beliefs, knowledge and skills which will enhance the effectiveness of their counseling relationships. Advocacy for multicultural counseling and substance abuse training for members of the Deaf community is essential for the promotion of cultural diversity in the

counseling field.

Recommendations for more effective cross cultural counseling

1. As a counselor, openly address issues of ethnic and or cultural differences. When the counselor raises issues such as deaf/hearing status, or ethnicity, it conveys a message of sensitivity and openness to these differences. The counselor's recognition and willingness to discuss these issues can facilitate the development of a therapeutic relationship. Counselors should also be honest about what they know or don't know about a client's information if the counselor indicates openness to learning from the client.

2. The counselor should evaluate the degree of either the client's status related to culture (i.e. integration, immersion, acculturation) acculturation or multicultural fluency by using cues from dress, daily activities, communication, language, family involvement, community involvement and body language and eye contact(Eldredge,1992). The counselor should also evaluate the clients' behaviors within the context of their predominate cultural identities.

3. When the client and counselor have significant cultural differences, the development of trust may be expected to take a longer time. A deaf client who has had repeated negative experiences with hearing teachers for example, may have a

difficult time trusting a hearing counselor. A white deaf woman may be uneasy working with a deaf African American therapist if she has experienced racial difficulties in her home town. Even in such situations, trust can develop, although it will probably happen slowly. Allow time for trust to develop before focusing on deeper feelings. Spend some of the initial session talking about neutral topics before focusing on counseling issues.

4. The standard counseling approach of establishing and maintaining eye contact also may have cultural implications. A Native American client, for example, may find eye contact uncomfortable based on the Indian culture. This may be especially perplexing for deaf clients who need to maintain some level of eye contact to access visual communication. The counselor should be aware that even if the client does not maintain eye contact, this does not mean that they are being disrespectful or not paying attention. Be sensitive to the fact that some cultures avoid eye contact and that the counselor should still use eye contact.

5. Confidentiality is an important and standard part of the counseling process. In serving members of the Deaf community, this is an especially crucial area. Members of the deaf community may be apprehensive about entering a counseling relationship for fear of the information shared in the session being told to others within the deaf community. A grapevine type

of communication has been common in the deaf community so deaf clients are often hesitant to discuss personal issues for fear that "everyone will know". The concept of confidentiality is foreign in the deaf community so deaf clients will need time to develop trust and experience that confidentiality can work.

6. A counselor who wishes to work with deaf clients needs to know the current climate and issues of concern in the Deaf community. For example, if the deaf community is currently supporting a bilingual, bicultural educational approach, these issues may surface in the therapeutic process. The culturally competent counselor will be aware of these dynamics and be able to understand this as a context for the client's issues.

7. The culturally competent counselor will be aware of cultural factors that actually are barriers to treatment and recovery and those that are not. For example, although it can be difficult for a recovering deaf person to find a deaf sponsor, a hearing sponsor can be accessed through a TTY, interpreter or relay service. The scarcity of recovering deaf people can be a barrier to recovery but is certainly one that a motivated client can overcome with information and support.

8. Pursue supervision with a professional who is knowledgeable about multi-cultural counseling issues. It is also helpful to cultivate a relationship with other professionals who can serve as a resource and as a support. Ideally, these other professionals will include some professionals who are deaf.

Bibliography

Bell, P. (1992). Cultural Pain and African Americans: Unspoken Issues in Early Recovery. Center City, Minnesota: Hazeldon Educational Materials.

Burn, D. (1992). Ethical Implications in Cross-Cultural Counseling and Training. Journal of Counseling and Development, 70, 578-583.

Cayleff, S. (1986). Clinical Issues in Counseling Gender, Race and Culturally Distinct Groups. Journal of Counseling and Development, 64, 345-367.

Eldredge N. & Hammond, S. (April,1992). Distant Visions: Two Studies of Deafness and Navajo Traditional Life. Hearing Health. pp.10-13.

Eldredge, N., (1992). Culturally Affirmative Counseling with Native Americans who are Deaf.(Unpublished Manuscript).

Everett, F., Proctor, N & Cartmell, B.(1983). Providing psychological services to American Indian children and families. Professional Psychology: Research and Practice. 14(5), 588-603.

Fitzgerald, K. & O'Leary, E. (1990). Cross-Cultural Counselling: Counsellor's Views on Barriers, Benefits, Personal Qualities and Necessary Preparation. The Irish Journal of Psychology, 238-248.

Glickman, N.(1983). A cross-cultural view of counseling with Deaf clients. Journal of Rehabilitation of the Deaf. 16(3), 4-14.

Glickman, N. & Zitter, S.(1989). On Establishing a culturally affirmative Psychiatric Inpatient Program for Deaf People. Journal of the American Deafness and Rehabilitation Association, 23(2), 56-59.

Kim, H. & Leong, F. (1991). Going Beyond Cultural Sensitivity on the Road to Multiculturalism: Using the Intercultural Sensitizer and a Counselor Training Tool. Journal of Counseling and Development, 70, 112-118.

Locke, D. (1991). The Locke Paradigm of Cross Cultural Counseling. International Journal for the Advancement of Counselling, 14, 15-25.

Locust, C.S.(1985). American Indian beliefs concerning health and unwellness. Disability and Rehabilitation. Monograph supported by the National Institute of Native American Research and Training Center. Tucson, AZ: University of Arizona.

Padden, C.(1980). The Deaf community and the culture of Deaf people. In C. Baker & R. Battison(Eds.), Sign Language and the Deaf Community (pp 89-103). Silver Spring, MD: Linstok Press.

Padden, C. & Humphries, T.(1988). Deaf in America, voices from a culture. Cambridge, M.A.: Harvard University Press.

Pederson, P. (1976). The triad model of cross-cultural counseling training. Personnel and Guidance Journal, 56(8), 94-100.

Richardson, E.H. (1981). Cultural and historical perspectives in counseling American Indians. In D.W. Sue(Ed.), Counseling the Culturally Different. (pp. 216-255). New York: John Wiley and Sons.

Rendon, V. (1992). Deaf Culture and Alcohol and Substance Abuse. Journal of Substance Abuse Treatment, 9, 103-110.

Rutherford, S.D. (1988). The culture of American Deaf people. Sign Language Studies, 59, 129-147.

Sabnani, H., Ponterott, J. & Borodovsky, L. (1991). White Racial Identity Development and Cross-Cultural Counseling Training: A State Model. The Counseling Psychologist. 19(1), 76-102.

Sabnani, H. & Ponterotto, J. (1992). Racial/Ethnic Minority-Specific Instrumentation in Counseling Research: A Review, Critique, and Recommendations. Measurement and Evaluation in Counseling and Development, 24, 161-187.

Schein, J. (1989). At home among strangers: Exploring the deaf community in the United States. Washington, D.C.: Gallaudet University Press.

Sue, D.W. & Sue, D. (1981). Counseling the Culturally Different: Theory and Practice, Second Edition. New York: John Wiley and Sons.

Vernon, M. (1990). The Psychology of Deafness. Longman of Addison: Wesley Publishing Company., Inc. p. 71.

Westwood, M. & Ishiyama, I (1990). The Communication Process as a Critical Intervention for Client Change in Cross-Cultural Counseling. Journal of Multicultural Counseling and Development, 18, 163-171.

Appendix I

Cultural Characteristics*

American Indian	Anglo	Deaf
present oriented	future oriented	past or present oriented
group emphasis	individual emphasis	group and individual emphasis
respect for age	emphasis on youth	emphasis on success
family oriented	self oriented	community oriented
lack of time consciousness	extreme time consciousness	relationships more important than time
learn through legends	learn through school	learn through stories
work for a purpose	work for retirement or to maintain lifestyle	work for money
land/nature oriented	possession oriented	emphasis on relationships/community
personal information is private	some personal information is private	personal information is public
touch and eye contact are avoided by acquaintances	touch and eye contact not commonly used by acquaintances	touch and eye contact are commonly used even among acquaintances

References*

Bellah, et. al., 1985
Carlson, 1975
Darou, 1987
Everett, Proctor and Cartmell, 1983
Glickman, 1983
Good and Good, 1986
Hall, 1986
Hanson & Eisenbise, 1982
Hardaway, 1984
Heinrich, Corbine, & Thomas, 1990
Hering, 1989
Joe & Miller, 1987
Katz, 1981
Lazarus, 1982
Littrell & Littrell, 1983
Lowrey, 1983
Padden, 1980
Padden & Humphries, 1988
Richardson, 1981
Rutherford, 1988
US Dept of Health and Human Services, 1980